Retain this stub as evidence to document that you have complied with the Communicable Disease Prevention and Control Act (Texas Health and Safety Code, Chapter 81)

Patient's Name:_____ **Disease:**_____ **Date Reported:** ____/____/____

Reported to:_____

Private Provider Initial Report Form
Texas Department of Health Confidential Morbidity Report

Please mail to your local health department in an envelope marked "Confidential"

1. Case Identification
Complete for all notifiable conditions except HIV infections in persons ≥13 years old.

2. Number of Chickenpox Cases: _____

Disease or Condition	Onset Date	Type of Diagnosis ☐ Clinical ☐ Culture ☐ Other ☐ Serology ☐ Biopsy/Smear	
Patient Name (Last, First, MI)	DOB (MM/DD/YY)	Name of Lab	Lab phone
Patient's Occupation	Age _____ Sex ☐M ☐F	Race _____ Hispanic? ☐Y ☐N	Pregnant? ☐Y ☐N ☐Unk / Died? ☐Y ☐N ☐Unk
Patient's Address (Street, City, State, Zip)		County	Phone

3. HIV Infections in Persons ≥ 13 Years Old
Complete sections 3, 6, and 7 for each newly diagnosed infection.

Last 4 Digits of Pt's SSN	County of Residence	City of Residence	Residence Zip

Sex	Race	Hisp? ☐Y ☐N	Date of Birth (MM/DD/YY)	Date Tested (MM/DD/YY)	Positive ELISA ☐ (report only if positive confirmatory test result is available). Positive Confirmatory Test: ☐ PCR ☐ Western Blot ☐ Other:

4. Syphilis, Gonorrhea, Chlamydia, and Chancroid
Also complete demographic data in Section 1.

STD Code (see inside cover)

Physical Exam Date (MM/DD/YY)

Disease: ☐ Syphilis ☐ Gonorrhea ☐ Chlamydia ☐ Chancroid

Stage: ☐ Primary (lesion) ☐ Secondary (symptoms) ☐ Early Latent ☐ Late Latent ☐ Congenital ☐ Other

Site: ☐ Genital, Uncomplicated ☐ Ophthalmia ☐ Pharyngeal ☐ PID/Acute Salpingitis ☐ Anorectal ☐ Other_____

Resistance: ☐ Penicillin ☐ Tetracycline ☐ Other _____

Specimen Collection Date	Test Type (RPR, VDRL, MHA-TP, FTA)	Results	Treatment Date	Medication	Dose

5. Sexually Transmitted Diseases, Voluntarily Reported
Report monthly by numeric totals for each sex.

Condition	Total Male	Total Female	Condition	Total Male	Total Female
Genital Herpes			Other (specify)		
Genital Warts			Other (specify)		
Non-specific Urethritis			Non-specific Vaginitis		
Other (specify)			Mucopurulent Cervicitis		

6. Reporting Agency Information

Date of Report (MM/DD/YY)	Reported By ☐ Physician ☐ ICP ☐ Lab ☐ Other:
Person Completing This Form	
Street Address, City, Zip	

7. Physician Name, Address, and Phone
Provide this information for all reports.

☐ **Check here to receive reporting pad.**